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TESTIMONY OF

Blue Cross & Blue Shield Association
An Association of Independent
Blue Cross & Blue Shield Plans

Before the

Subcommittee on Civil Service and Agency Organization
Committee on Government Reform
United States House of Representatives

On

"Healthier Feds and Families: Introducing Information Technology into the Federal Employees Health Benefits Program, a Legislative Hearing on H.R. 4859, Part II"

Presented by:

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Good morning. Chairman Porter, Ranking Member Davis, and Members of the Subcommittee, I am Stephen Gammarino, Senior Vice President, National Programs, of the Blue Cross and Blue Shield Association. Thank you for this opportunity to present the views of the Blue Cross and Blue Shield Association Federal Employees Program on the Federal Family Health Information Technology Act of 2006, H.R. 4859.

The Blue Cross and Blue Shield Association and participating Blue Cross and Blue Shield Plans jointly administer the Government-wide Service Benefit Plan in the FEHBP. We are proud to have offered the Service Benefit Plan from the very beginning of the FEHBP in 1960. Today, the Service Benefit Plan provides high-quality, affordable health insurance to more than 4.6 million active and retired federal employees and their families. By their choice to enroll in one of the options we offer, the Service Benefit Plan has become the largest plan in the Program.

My testimony today will focus on three areas:

I. The Association and Blue Cross and Blue Shield Plans' strong support and commitment to advancing health information technology, including examples of what we are currently doing;

II. An overview of OPM's market-oriented approach, which has contributed to the success of the FEHBP program by relying on strong competitive forces rather than regulation; and

III. Our concerns with the bill and our recommendation to advance Personal Health Records (PHRs) in the FEHBP through a market-oriented process with active congressional oversight.

THE ASSOCIATION AND BLUE CROSS AND BLUE SHIELD PLANS ARE COMMITTED TO ADVANCING HIT.

The Association commends you, Mr. Chairman, and the members of the subcommittee for your interest in Health Information Technology. The Association is very supportive of advancing health IT in general and of offering PHRs in the FEHBP in particular. (We use "PHR" to encompass both the carrier-based electronic health record and the personal electronic health record established by the bill.)

Blue Cross and Blue Shield Plans are committed to a health care system that delivers safe, efficient, and high-quality care for consumers – giving consumers greater value for their health care dollars – as well as increased administrative efficiency for providers, payers, government, and consumers. Achieving this goal requires nationwide adoption of health information technology (IT) that is based on interoperability standards that support the exchange of clinical and administrative information among providers, payers, government, and consumers, and that includes the tools providers need to deliver high-quality, evidence-based health care.

We especially applaud your decision, Mr. Chairman, to embrace payer-based electronic health records. Payer-based records are a natural extension of what insurers do because they are compiled from claims data submitted by providers to health plans: diagnoses, procedures, medication history, immunizations, recent health encounters, etc. More important, payer-based EHRs are particularly exciting because health plans are generally the only stakeholder in the health care system that collects information from almost all providers that their members visit and, therefore, the only stakeholder at this time that can give a physician a cross-provider view of a patient's history. Carriers are also uniquely positioned to integrate electronic health records

with disease and care management programs that benefit those with the most challenging health problems. Payer-based PHRs will also facilitate the use of clinical tools and evidence-based medicine at the point of care.

Association Leadership on HIT

The Association's commitment to advancing health IT has been demonstrated by our actions. Scott Serota, the Association's CEO, serves, along with OPM Director Springer and others, on the American Health Information Community ("the Community"). As you know, HHS Secretary Leavitt appointed the Community, which comprises representatives of all of the key stakeholders - both public and private - in the healthcare industry, to advise him on how best to advance health information technology. Under the Secretary's leadership, the Community provides a forum in which a broad range of stakeholders provide input on achieving interoperability of health IT, and it will recommend specific actions to achieve a common interoperability framework for health IT.

When he accepted this appointment, Mr. Serota emphasized that "Blue Plans are leaders in advancing health IT, including interoperable systems, personal health records, e-prescribing, and information sharing to improve care, as well as other projects," and that "We look forward to working with other key stakeholders to advance the nationwide adoption of health information technology. This will enable safer, more efficient and higher quality care for all."

We have also joined forces with America's Health Insurance Plans (AHIP) –and are coordinating with the Health Information Technology Standards Panel – in a collaborative effort to define the minimum data elements of personal health records (PHRs) and develop standards to facilitate their interoperability and portability. The FEP is participating in this critically important project.

The Association has also supported legislation that would spur the development of industry-wide interoperability standards. For example, the Association has endorsed those provisions of H.R. 4157 that would establish such standards through public-private collaboration and harmonize state and federal privacy and health IT laws.

Plan Leadership on HIT & Lessons Learned

Many of our Plans are in the forefront of implementing PHRs and other innovative advances in health IT. Let me just briefly highlight a few examples, some of which are already known to the subcommittee:

- BCBS of Delaware and the Christiana Care Health System have developed a system for providing Christiana's emergency room doctors with real-time health records on the Plans' members.
- BCBS of Texas, aware of the debilitating effects Hurricane Katrina had on the delivery of health care to many affected by the hurricane, undertook the Herculean task of creating 830,000 PHRs for its members who were threatened by Hurricane Rita. (I am pleased to reassure members of the subcommittee that the Service Benefit Plan is already well equipped to provide our members access to their health information, including prescription drug information, in the event they are affected by a disaster.)
- HCSC, of which the Texas Plan is a division, is implementing PHRs for its members.

- Arkansas BCBS, two of Arkansas's major providers, and IBM established the Arkansas Health Information Network in 1995, one of the first interoperable networks for exchanging health information between payers and providers, including since 1996 electronic health records.

The experiences of these Plans and others have yielded valuable lessons. Let me mention a few:

- Non-proprietary interoperability standards are critical to facilitate the exchange of data.
- Providers must see value in such records and they must be integrated into the providers' workflow in order to spur adoption.
- Members must see value in using their PHRs.

OVERVIEW OF OPM'S FLEXIBLE, MARKET-ORIENTED APPROACH

Historically, the strength of the FEHBP – which has made it a model employer-sponsored health benefits program – has been its reliance on the market forces of competition and consumer-choice, which has provided OPM and carriers the flexibility necessary to adapt to changing conditions and emerging trends. Unlike Medicare, another government health program, Congress has exercised a "light touch" and restraint in imposing statutory specifications. We believe that reliance on the marketplace and the freedom to innovate afforded to carriers are features that have made the FEHBP successful for more than forty years.

OPM'S Call Letter for 2007

OPM's call letter for 2007 prescribes a market-oriented path that harnesses both financial incentives and consumer empowerment to advance health IT in the FEHBP. Under that call letter, FEHBP carriers are expected to meet five short-term objectives:

1. Enhance member education on how health information technology can help improve health care quality and control costs in the long run;

2. Offer payer-based PHRs to enrollees based on information currently available in their systems;

3. Encourage pharmacy benefit managers to provide incentives for ePrescribing; and

4. Link disease management programs to health information technology;

5. Comply with federal requirements to protect members' individually identifiable health information.

Within the next two to four years HIT adoption will become an element in each carrier's performance review, which determines the amount of each carrier's service charge. In the upcoming open season, prospective employees will be able to review information on carriers' HIT capabilities on OPM's website as they decide which health care plan to choose for 2007. The agency will also highlight plans with "state-of-the art HIT capabilities."

The Market-Oriented Approach Has Already Led To HIT Advancements in the Service Benefit Plan.

The market-based model reflected in the call letter and the Association's commitment to health IT have already led to advances in the Service Benefit Plan and we believe it will serve the introduction of PHRs equally well. I would like to review some of those advances for the benefit of the subcommittee.

We have worked closely with OPM for several years on an important, member-centric program, called Care Coordination. Care Coordination applies health information technology to an integrated database in order to improve our members' health care.

Care Coordination focuses on those with chronic conditions, diabetics for example. Under it, we will use claims data, including prescription drug information, and information from enrollment forms to identify those members who would benefit from our Plans' disease or case management programs, to work with our local Plans to educate those members about the benefits of such programs, and, we hope, to persuade members to take advantage of those programs. Initially, Care Coordination will provide a single point of entry to a seamless health care system for Plan disease and care management directors. But our goal is to extend access to this data to providers and then, in the next stage, to develop a mechanism to allow individual members to access their own data.

Currently, eleven Plans are participating in this program. We anticipate that all Plans will be part of the program by 2008. We believe the implementation of this program will substantially improve the health care received by those who need it most and strengthen their ability to manage their medical conditions.

Many believe, as Dr. Paul Handel, the Vice President and Chief Medical Officer of Blue Cross Blue Shield of Texas, testified before this subcommittee in March, that PHRs will have the greatest values for our sickest members, those who need care or disease management programs. Accordingly, among several other options, we are examining whether it would be appropriate to pilot PHRs in our Care Coordination program.

We have also strongly supported another HIT initiative, e-prescribing to improve patient safety and reduce drug costs by delivering patient-specific drug benefit and medication history to physicians at the point of care. Working with our PBM (Caremark) and two Plans (Horizon Blue Cross and Blue Shield in New Jersey and Blue Cross Blue Shield of Tenessee), we are conducting a pilot program to encourage high prescribers to adopt this technology by providing incentives, including the purchase of software and funding other start-up costs. Thirty-four physicians in Tennessee and ninety-seven in New Jersey have enrolled in the program.

I would also note that Blue Cross and Blue Shield Service Benefit Plan members may already use the Health Tracker feature of the web-based Blue Health Connection (the Service Benefit Plan's health information site) to store health information on themselves and their families on a confidential basis.

Market Approach is Superior to Legislated Mandates

In our view, the call letter's flexible, market-oriented approach in which carriers work closely with OPM to develop electronic health records that truly reflect their members' values and keep pace with developments in the health care industry as a whole is the best approach for developing PHRs in the FEHBP. Let me explain why. It:

- **Relies on Market Incentives Rather than One-Size Fits All Mandates.**

OPM's market-driven approach harnesses both financial incentives and consumer empowerment to direct the development of HIT. Carriers that are slow to offer PHRs, for example, risk punishment in the marketplace as consumers who value them gravitate to other carriers.

- **Recognizes that Each Carrier Is the Best Judge of Its Members' Needs**

Each carrier will know best how to meet the needs of their own members. Some may put the highest priority on developing PHRs, while others might persuade OPM that their scarce IT resources should be allocated first to other HIT initiatives, such as e-prescribing or care management. The call letter does not impose a "one-size-fits-all" mandate.

- **Facilitates Pilot Projects That are Critical to Success.**

Pilot projects are critical in our view to the effective development of PHRs. Unless our members actually make use of their PHRs and there is widespread acceptance among providers, the electronic health records called for in the bill simply will not have the impact we all hope for. These are key non-technological challenges and pilot tests will likely be critical to developing and refining PHRs that members will perceive as an attractive tool they want to use and that providers will accept. Moreover, since we are just now beginning to learn what information is useful and how to educate consumers and providers of the value PHRs can provide, the flexibility to continue to innovate is essential.

The call letter allows us to work with the agency in conducting the necessary experiments and to refine our PHR and our educational efforts in line with our experience to most effectively meet our members' values without the constraints imposed by arbitrary deadlines. In contrast, there is no explicit provision in the bill for pilot programs, and the bill's firm deadlines are likely to preclude them.

- **Focuses on PHRs as Means Not Ends**

The ultimate goal of PHRs is to improve the quality, safety, and efficiency of health care for those who participate in the FEHBP. In contrast, requiring carriers to establish PHRs in accordance with tight and inflexible deadlines tends to focus on PHRs as ends rather than means and is more likely to benefit vendors who market proprietary PHRs than the active and retired federal employees and dependents who rely on the FEHBP for their health care coverage. Carriers will be pressured to

offer a product by a date certain rather than take the time necessary to develop one that best reflects their members' values.

CONCERNS AND RECOMMENDATIONS

I would like to discuss some of our major concerns with this legislation, explain why we believe no legislation is necessary to advance PHRs, and recommend the market-oriented path described in OPM's call letter as a superior route for introducing PHRs into the FEHBP.

Concerns

At the very least, we believe this legislation (or any other mandatory legislation) is premature. The standards needed to support PHR functions, interoperability, and portability required by the bill simply do not exist today. Many organizations, including BCBSA and other private and public bodies, are working hard to develop such standards. But there can be no assurance they would be thoroughly tested and in place when the bill's various deadlines fall.

Because we firmly believe that the FEHBP's reliance on market competition and consumer choice have been its strengths, the Association has historically objected to statutory mandates on the program – and, indeed, even to overly prescriptive call letters. This bill would establish an unprecedented mandate on how FEHBP carriers deploy their information technology resources and other internal infrastructure. Carriers would not have the flexibility they need to direct their resources in the manner that would most effectively meet their members' needs. Thus, we are very concerned that the bill would establish a dangerous precedent for other legislation that would dictate the internal business processes of FEHBP carriers. The Service Benefit Plan is fully integrated with Local Blue Cross and Blue Shield Plans' commercial business. Accordingly, this mandate is particularly problematic for us since it could affect our Local Plans' commercial business operations.

Section 3 of the bill is particularly problematic and not workable.

First, it would change current law to deny the inclusion of valid costs associated with the development of PHRs in the setting of a plan's premiums. This would be an uncompensated burden on carriers. Section 3 mistakenly attempts to offset these costs by providing that neither monetary savings nor returns on investment resulting from PHRs will be taken into account in rate setting. Again, section 3's premise is false in that experience-rated carriers, such as the Service Benefit Plan, have no way of taking into account "savings" on benefits costs; only the actual costs incurred are used in setting rates. While reducing benefit costs is always a goal, it would be impossible to attribute specific reductions in benefit costs to the introduction of PHRs as opposed to other system changes and administrative actions.

Second, and equally adverse, section 3 would also change the longstanding statutory provision whereby the unused portion of OPM's administrative reserve is rolled into carrier's contingency reserves for the payment of claims and rate stabilization. This would not only establish a dangerous precedent of using the contingency reserves for other than the statutorily-intended purposes, but would cause an upward pressure on a plan's premiums by the amount of the foregone reserves.

In short, section 3 not only is unworkable, but it does not accomplish either of its stated purposes**.**

Legislation is Unnecessary to Bring PHRs Into the FEHBP

There is already a high level of activity that will facilitate the introduction PHRs. An HHS contractor will recommend PHR standards to the Community by September 30, 2006, and Secretary Leavitt has said that he expects federal agencies to incorporate them in their health care contracts. The BCBSA/AHIP joint venture is also following an aggressive schedule that calls for the development of standards in August. Just as legislation was not required to introduce Care Coordination or our e-prescribing incentives, we do not believe it is necessary to bring PHRs to the FEHBP. To put it simply, OPM's call letter guarantees that interoperable PHRs are coming to the FEHBP in timely fashion.

In keeping with our long tradition of providing first-rate health care coverage to federal employees and retirees, the Association is committed to being a leader in the *effective* use of health IT in the FEHBP and has begun market research on PHRs. We recognize that unless enough of our members actually use their health records, the promise of PHRs will remain unfulfilled. Therefore, one of the key challenges we face is to develop a PHR that our members will perceive as a value and want to use. For those reasons, we are conducting market research to better understand what consumers know about PHRs, what their concerns are, what would be valuable to them, and what barriers might prevent our members from making effective use of a PHR. We will use what we learn about our members' values, as well as lessons we learn from the experiences of the many Blue Plans that offer PHRs, to develop a PHR and pilot test it in the FEHBP as appropriate.

Recommendation

We strongly recommend that OPM and carriers be permitted to follow the market-based path set forth in OPM's call letter with active congressional oversight to hold the agency and carriers accountable for achieving the bill's objectives with strong congressional oversight. This approach will provide OPM and carriers the flexibility they need to ensure that the PHRs offered to our members truly reflect their values and maximize the prospect that they will be used. But it will also afford congress ample opportunity to hold the agency and carriers for meeting the objectives of the bill.

Congress obviously has a legitimate interest in ensuring that the FEHBP offers federal employees and retirees the benefits that technology can offer when effectively deployed. We believe, however, that congressional oversight would make a far more constructive contribution than legislated mandates. Congress has many oversight tools available, including conducting hearings and requiring periodic reports from OPM on the progress in advancing PHRs and other health IT components in the FEHBP. We would welcome and strongly encourage congressional oversight to hold both the agency and FEHBP carriers accountable for achieving the objectives of H.R. 4859 in a timely fashion. We are confident that you will find the Blue Cross and Blue Shield Service Benefit Plan a leader in bringing health PHRs to our members in an effective manner.

CONCLUSION

The Blue Cross and Blue Shield Service Benefit Plan shares your commitment, Mr. Chairman, and that of the Subcommittee, to bring PHRs to the FEHBP. We believe that if properly deployed and used PHRs and health IT in general hold much promise for improving the quality and safety of healthcare, as well as helping to control costs.

However, we do not believe H.R. 4859 is either necessary or the best way to achieve the goal of bringing the benefits of health information technology to the FEHBP. It is not necessary because OPM has already indicated that it expects Plans to focus on offering PHRs and has prescribed a flexible, market-oriented path for achieving that goal. We believe that approach is best calculated to allow us to work with OPM to develop a product that best serves our members' interests and encourage active congressional oversight to hold the agency and carriers accountable. Until industry-wide standards for portability and interoperability and to define core elements of PHRs are developed, thoroughly tested, and in place, we believe legislation is, at best, premature.